

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>004683</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>04/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>INDIANA UNIVERSITY HEALTH BEDFORD HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2900 W 16TH ST BEDFORD, IN 47421</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of a State hospital complaint.</p> <p>Complaint Number: IN00126784 Unsubstantiated: Lack of sufficient evidence.</p> <p>Date: April 15, 2013</p> <p>Facility: #004683</p> <p>Surveyor: Billie Jo Fritch RN, MBA, MSN Public Health Nurse Surveyor</p> <p>Indiana University Health Bedford Hospital was found in compliance with State Rule 410 IAC 15-1.5-8, Physical Plant, maintenance, and environmental services.</p> <p>QA: cloughlin 04/23/13</p>	S 000			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

DHTR11

If continuation sheet 1 of 1